

Chapter 1: Introduction

The overall health of Americans has improved dramatically nationwide over the last 100 years. Successful public health interventions and advances in technology and research have extended the average life span from about 47 years in 1900 to over 76 years in 1999.¹ Unfortunately, not every segment of the population is benefiting equally from this progress; in fact, there are clear disparities in life span, health status, and health care use among different racial, ethnic, and socioeconomic groups within the United States.

It is also clear that there are significant differences and shifts in the use of health care services by these populations. For example, the U.S. health care system in the last 10 years has produced significant reductions in infant mortality, record-high rates of childhood vaccinations, declines in substance abuse, lower death rates from coronary and heart disease, and promising new treatments for cancer.² At the same time, data from numerous sources show that some racial, ethnic, socioeconomic, and geographic groups suffer disproportionately from preventable or treatable chronic conditions.

Using a broad array of data sources, this report describes the scope and characteristics of differences in health care quality and access associated with patient race, ethnicity, income, education, and place of residence. It also enhances understanding of where disparities in health care exist, emphasizes the need for greater clarity regarding the interpretation of disparities, and makes clear where data are limited for making an accurate assessment at this time.

What Are “Health Care Disparities”?

The word “disparity” can be defined as “the condition or fact of being unequal, as in age, rank, or degree.” Synonyms for disparity include *inequality*, *unlikeness*, *disproportion*, and *difference*. While disparity in health care has been closely associated with equity, there are several potential reasons for the differences observed at the individual level. For example, a patient may receive fewer medications because of differences in underlying disease processes, individual choice, systemic barriers to obtaining needed medications, or some combination of these reasons. When we observe differences in health care for different populations, it may not be possible to clarify causal pathways directly. The purpose of this report is to describe differences in quality of and access to health care to help identify disparities in health outcomes that may be responsive to improvements in health care.

Disparities are most easily identified when there is a clear reference point for what is appropriate and reasonable to expect. While there may be uncertainty regarding many aspects of clinical care, the quality measures presented here have been developed around health care interventions for which there is sound scientific evidence of effectiveness and for which there is a professional consensus and expectation that these services would be provided to all patients. Even after consideration of variation in patients’ medical

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conditions and severity of illness, there should be little deviation from specific quality measures by population.

Access to health care is a prerequisite to obtaining quality care. However, dimensions of access vary in predicting an individual's likelihood of receiving care that has been shown to improve health outcomes. For use of services, patient-reported experience of care, and structural issues such as transportation, there is limited scientific consensus regarding which measures are most responsive to system improvements. In addition, the most important factors may not be consistent across communities and populations.

This report presents a broad array of differences related to access, use, and patient experience of care by racial, ethnic, socioeconomic, and geographic groups, based on valid measures. Many of the differences presented here are large and worrisome; indeed, some will argue, quite reasonably, that they constitute evidence of disparity, irrespective of a clear relationship to health outcomes. Further evaluation of these data should prove helpful in assessing current efforts to address important disparities in access to care.

The task of interpreting the data and synthesizing it is complex. First, as noted above, many factors may lead to differences in health care, especially with respect to aggregate measures of use. These include different underlying rates of illness due to genetic predisposition, local environmental conditions, or lifestyle choices. There are differences in the care-seeking behavior of patients, which vary due to differing cultural beliefs, linguistic barriers, degree of trust of health care providers, or variations in the predisposition to seek timely care. In addition, the availability of care is dependent upon such factors as the ability to pay for care (directly or through insurance coverage), the location, management and delivery of health care services, clinical uncertainty, and health care practitioner beliefs, among others.

Second, there may be differing perspectives regarding the appropriate division of responsibility between the individual, the public sector, and the private sector. Third, to the extent that defining a difference establishes it as a priority for action, it is not clear that reliance upon a consistent numerical threshold is appropriate. For some measures reported here, a small differential could be critical; for others, a differential may not be critical unless it is very large. It will be important to take into account the impact on patients of the differential.

Last, how the patient characteristics assessed in this report—race, ethnicity, income, education, place of residence, age, and others—affect quality of and access to health care are both independent and additive. This first *National Healthcare Disparities Report* presents descriptive information for each but does not assess which characteristics are most important for improving health care.

Our National Goals

Inequalities in health care that affect some racial, ethnic, socioeconomic, and geographical subpopulations in the United States ultimately affect every American. From a societal perspective, we aspire to equality of opportunities for all our citizens. Persistent disparities in health care are inconsistent with our core values.

Demographic trends indicate that the number of Americans who are vulnerable to suffering the effects of health care disparities will rise over the next half century. Current data show that some ethnic minorities, as well as low-income families of whatever race or ethnicity, tend to be in poorer health than other Americans. Gaps in income between the richest and poorest households in America are widening, with serious potential implications. Also, some racial and ethnic minorities are growing at a much more rapid pace than the majority white population. The U.S. Bureau of the Census reports that white Americans currently constitute 71% of the population, but nearly 1 in 2 Americans will be a member of a racial or ethnic minority—i.e., black, Hispanic, Asian, or American Indian—by the year 2050.³ Clearly, these trends pose a daunting challenge for policymakers and the health care system.

Also critical, health care disparities are costly. Poorly managed care or missed diagnoses result in expensive and avoidable complications. As the Institute of Medicine (IOM) suggests in its seminal 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, “to the extent that minority beneficiaries of publicly funded health programs are less likely to receive high quality care, these beneficiaries—as well as the taxpayers that support public health care programs—may face higher future health care costs.”⁴

In addition to costs directly borne by taxpayers, unfortunate outcomes resulting from health care disparities may contribute to higher health insurance and malpractice premiums, both of which threaten the viability of our health care system. And, while difficult to quantify precisely, the costs of lost productivity and the indirect costs to families are doubtless very high.

For all of these reasons, the elimination of health care disparities resulting from unequal opportunities is a top public policy priority. In response to congressional and national mandate, the U.S. Department of Health and Human Services (DHHS) is undertaking a number of initiatives toward this end.

Why a National Healthcare Disparities Report?

Public Law 106-129, the Healthcare Research and Quality Act of 1999, directed the Agency for Healthcare Research and Quality (AHRQ) to develop two annual reports: a National Healthcare Quality Report (NHQR) and this National Healthcare Disparity Report (NHDR). The directive for this report, now contained in section 903(a)(6) of the

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Public Health Service Act, requires that this annual report tracks “prevailing disparities in health care delivery as they relate to racial factors and socioeconomic factors in priority populations.”⁵

With guidance from the Institute of Medicine, AHRQ developed a common conceptual framework for both reports and, in fact, a focus on quality is at the heart of both reports. As the IOM noted in its report, *Guidance for the National Healthcare Disparities Report*, the “plan to make health care quality a major focus of this report...is appropriate since disparities often represent an ‘inequality in quality.’”⁶ As a result, both reports are being released simultaneously and readers are urged to review both reports together to develop a more comprehensive snapshot of the performance of our health care system, its strengths, and areas that should serve as a focal point for future improvement. The performance measures underlying the two reports will be used to monitor the Nation’s progress toward improved health care delivery.

This first NHDR provides a national overview of racial, ethnic, and socioeconomic disparities in health care in the general U.S. population and among priority populations (defined below) to contribute to the public dialog on how to improve health care delivery for all Americans. It is important to note that this report is unique in providing a systematic overview of differences in health care for both racial and ethnic groups as well as by socioeconomic status. This is the first comprehensive look at differences by socioeconomic groups. Although not designed to measure the progress of any one program or policy, the data and analyses presented in the report are intended to provide a convenient and comprehensive source of information spanning a broad range of health care disparity issues.¹

Objectives of the First Report

A vital step in the effort to eliminate health care disparities is the systematic collection and analysis of health care data. This will help policymakers and researchers discern the areas of greatest need, monitor trends over time, and identify successful programs for addressing those needs. This first NHDR builds on and seeks to complement existing work in the area of disparities, notably *Healthy People 2010* and *Unequal Treatment*. Yet those efforts differ from the NHDR in substantive ways.

Healthy People 2010 has, as its second goal, the elimination of disparities in health.⁷ In contrast, the NHDR focuses on disparities in health care, rather than disparities in health. While conceptually different, the two efforts are integrally related. Disparities in health care can only be interpreted within the context of disparities in health. Disparities in

ⁱ “We need an annual report to measure whether we are making progress in ending racial disparities in health care and improving the quality of life for all Americans,” said U.S. Representative Danny K. Davis (D-IL) when introducing the amendment calling for the NHDR. He added: “This amendment is designed to try and make sure that we have adequate and accurate information on which to base policy and budgetary decisions.”

health help identify critical disparities in health care with which they are associated. Eliminating disparities in health care is a logical method for eliminating associated disparities in health.

Unequal Treatment extensively documents health care disparities in the United States by race and ethnicity.⁸ The IOM's examination finds that disparities in health care are substantial, even after accounting for characteristics typically associated with disparities, such as health insurance coverage and income. But while *Unequal Treatment* demonstrates definitively that racial and ethnic disparities in health care exist, it does not measure the magnitude of the problem from a national perspective. The report also does not address disparities in access to health care or disparities related to socioeconomic position.

In contrast, the NHDR examines national disparities in both the ability of Americans to access health care and in the quality of health care. It includes an analysis of disparities related to socioeconomic position as well as to race and ethnicity, and attempts to capture the relationship between race/ethnicity and socioeconomic position. The report provides baseline data from which we may be able to measure the effect of national initiatives to reduce disparities.

Objectives of Future Reports

Future reports will reflect our evolving understanding of disparities in access, use, and patient experience of care. These reports will go beyond measures of health care disparities to probe the underlying causes of the differences. Race and ethnicity are associated with various disparities in health care, but the root causes are likely multifactorial and complex. Identifying them and understanding their dynamics is key to designing effective interventions.

Subsequent NHDRs will also track disparities over time, include measures unique to specific populations, and add analyses of disparities along the rural-urban continuum. Longitudinal studies will be needed to monitor the Nation's progress to the elimination of disparities. Population-specific measures are needed to understand differences within different groups more fully. To improve the validity of all these measures, AHRQ will work with public and private groups to define and standardize core elements of national and subnational surveys.

Which Groups Are Included in the Report?

The statutory mandate for this report refers to "priority populations," a term that is defined in AHRQ's authorizing statute (section 901 (c) of the Public Health Service Act) as encompassing both specific population groups as well as geographically defined groups. In accordance with these guidelines, the NHDR includes data and analysis on the following:

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- Low-income groups
- Racial and ethnic minority groups
- Women
- Children
- The elderly
- Individuals with special health care needs, specifically children with special needs, the disabled, people in need of long-term care, and people requiring end-of-life care.

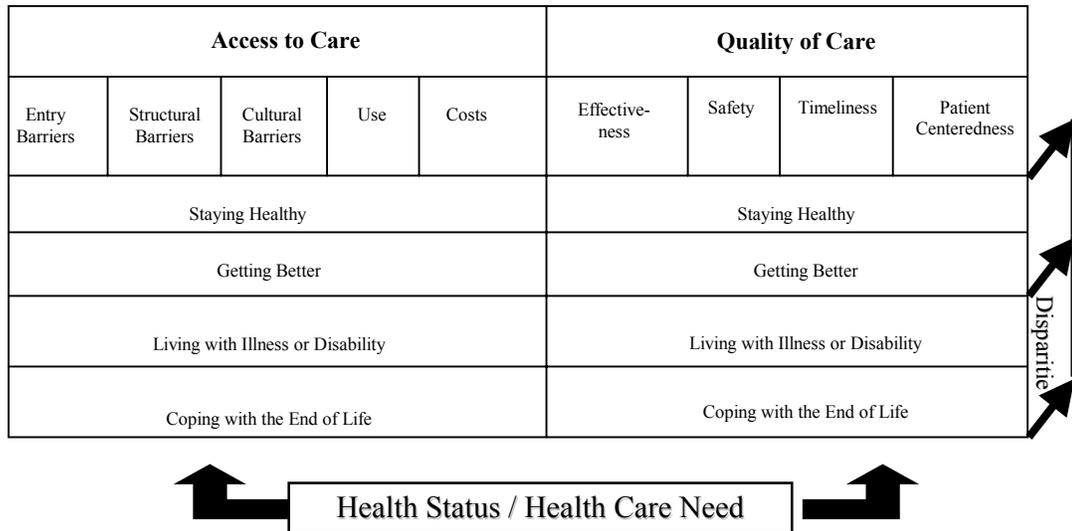
Rural populations are also included. Although other demographic groups may also suffer from health care disparities, they are not considered in this report.

Conceptual Framework

The IOM worked with AHRQ to develop the conceptual framework for the NHDR. Through public meetings and commissioned reports from experts in the field, the IOM received input from a wide variety of stakeholders, and built on the conceptual framework it had previously prepared for the NHQR.⁹ Its recommendations for the NHDR were released as the *Guidance for the National Healthcare Disparities Report* in September 2002.¹⁰

The NHQR's conceptual framework defines, measures, and seeks to relate components of health care quality (safety, effectiveness, patient centeredness, and timeliness) and health care needs from the consumer's perspective (staying healthy, getting better, living with illness or disability, and coping with the end of life). The NHDR conceptual framework (Figure 1) expands this model in three ways.

First, as an expansion of the equity section of the NHQR, the NHDR framework adds a third dimension to represent racial/ethnic and socioeconomic disparities. Additionally, since disparities in health care encompass far more than disparities solely in the quality of clinical encounters, the NHDR framework adds measures of access to and receipt of care. Finally, because disparities in health care are interpreted in the context of underlying disparities in health, this conceptual framework rests on a representation of disparities in health status and health care need.

Figure 1. National Healthcare Disparities Report Conceptual Framework

IOM Recommendations

The IOM's Committee on Guidance for Designing a National Healthcare Disparities Report made seven recommendations to focus analysis and discussion of the NHDR data and to guide future efforts:

1. The National Healthcare Disparities Report should present analyses of racial and ethnic disparities in health care in ways that take into account the effects of socioeconomic status.
2. AHRQ should pursue a research initiative to more accurately and meaningfully measure socioeconomic status as it relates to health care access, service utilization, and quality.
3. Access is a central aspect of health care quality. As such, the National Healthcare Disparities Report should give it prominent attention.
4. The National Healthcare Disparities Report should include measures of high utilization of certain health care services that indicate poor health care quality. It should also include measures of low utilization of certain health care services, which are more commonly used to indicate poor health care quality.
5. The National Healthcare Disparities Report should present data on disparities at the state level. It should also present data on disparities along a rural-urban continuum.
6. In the future, if AHRQ continues to rely on subnational data sources for the National Healthcare Disparities Report, it should work with public and private organizations to identify core elements and standardize these surveys.

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7. AHRQ should receive adequate resources to develop data sets and measures needed for the National Healthcare Disparities Report.

Organization

The report is organized to maximize accessibility and reinforce its conceptual framework. This chapter reviews the background and rationale for the report; Chapter 2, Methods, discusses the sources, selection criteria, and limitations of the data.

The report presents racial, ethnic, and socioeconomic differences within the general population in the provision of health care in relation to quality (Chapter 3) and access (Chapter 4). Disparities in priority populations (Chapter 5) discusses disparities of health care for the designated priority groups of women, children, elderly, racial and ethnic subpopulations, rural populations, and individuals with special needs. Conclusions (Chapter 6) summarizes the scope and nature of health care disparities in the United States, discusses data issues emerging from the report, and suggests directions for the report in future years.

References

¹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. *Health, United States, 2002. With Chartbook on Trends in the Health of Americans*. Hyattsville, MD., 2002. Table 28, Life expectancy at birth, at 65 years of age, and at 75 years of age, according to race and sex: United States, selected years 1900-99, p. 116.

² U.S. Department of Health and Human Services. *Healthy People 2010*. (Conference Edition, in Two Volumes). Washington, DC, January 2000.

³ U.S. Bureau of the Census. 2000. <http://www.census.gov> Accessed March 15, 2001.

⁴ Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. (2003) National Academies Press.

⁵ Institute of Medicine, Committee on the National Quality Report on Health Care Delivery. *Envisioning the National Healthcare Quality Report*. 2001. Hurtado, Margarita P., Swift, Elaine K., Corrigan, Janet M., eds. Washington, DC. National Academies Press.

⁶ Institute of Medicine, Committee on Guidance for Designing a National Healthcare Disparities Report. *Guidance for the National Healthcare Disparities Report*. (2002). Elaine K. Swift, ed. Washington, DC. National Academies Press.

⁷ U.S. Department of Health and Human Services, *Healthy People*, pp. 11-16.

⁸ Institute of Medicine, *Unequal Treatment*, Chapter 2, The healthcare environment and its relation to disparities (pp. 29-80); Chapter 3, Assessing potential sources of racial and ethnic disparities in care: Patient- and system-level factors (pp. 125-59), Chapter 4, Assessing potential sources of racial and ethnic disparities in care in the clinical encounter (pp. 160-79).

⁹ Institute of Medicine, Committee on Guidance for Designing a National Healthcare Disparities Report. *Guidance for the National Healthcare Disparities Report*. (2002).

¹⁰ Institute of Medicine, Committee on Guidance for Designing a National Healthcare Disparities Report. *Guidance for the National Healthcare Disparities Report*. (2002). Elaine K. Swift, ed. Washington, DC. National Academies Press.